STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155782	A. BUILDING 01 B. WING	11/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK HEALTH CAMPUS	814 S 6TH ST MONTICELLO, IN47960

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K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 11/02/11 Facility Number: 012355 Provider Number: 155762 AIM Number: 201014410 Surveyor: Bridget Brown, Life Safety Code Specialist At this Life Safety Code survey, White Oak Health Campus was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies and 410 IAC 16.2. The one story, fully sprinklered facility was determined to be Type V (111) construction. The SNF	K0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	certified health care occupancy was located on north end of the main building with a capacity for 61 residents and a census of 38 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 11/09/11. The facility was found not in compliance with the aforementioned requirements as evidenced by:			
K0029 SS=E	Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1 1. Based on observation and interview, the facility failed to provide an automatic closer for the door providing access to 2 of 10 hazardous areas such as a combustible materials storage rooms larger than 50 square feet. Sprinklered hazardous areas are required to be equipped with self closing doors or with doors that close automatically upon	K0029	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;No residents were found to have been affected. All rooms being utilized for storage have been emptied and are no longer utilized for storage. Therefore the self closing device is not needed for these rooms. The latch on the door in the 300 hall smoke compartment has been repaired and is now latching. How	12/02/2011

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	activation of the fire alarm system. This deficient practice could affect visitors, staff and 6 residents on the 300 hall. Findings include: Based on observation with the maintenance director on 11/02/11 between 11:30 a.m. and 2:30 p.m., resident rooms 314 and 315 were used for the storage of cardboard cartons and other combustible materials. The corridor doors had no self closing device. The maintenance director said at the time of observation, the rooms were not meant to be used for storage. 3.1-19(b) 2. Based on observation and interview, the facility failed to provide a working latch for the 1 of 3 hazardous area doors in the 300 hall smoke compartment. Doors in sprinklered hazardous areas are required to latch upon self closing. This deficient practice could affect visitors, staff and 6 residents on the 300 hall.		other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken;6 residents on the 300 hall were identified to have the potential to be affected however no residents were found to have been affected. All rooms being utilized for storage have been emptied and are no longer utilized for storage. Therefore the self closing device is not needed for these rooms. The latch on the door in the 300 hall smoke compartment has been repaired and is now latching. What measures will be put into place or what sysemic changes will be made to ensur that the deficient practice does ot recur;The rooms which had been utilized for storage are intended for resident occupancy. These rooms will be utilized for resident occupany as the need arises. Items needing stored will be placed in areas meeting the criteria for storage. How the corrective action(s) will be monitored to ensure the deficient practice will not recur;DPO will conduct rounds 3x weekly x 4 weeks, then weekly x 6 months to ensure these rooms are not utilized for storage. Results of these rounds will be shared with QA committe for review and changes will be made as appropriate. All systemic changes will be completed by 12/2/11.	

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	Findings include: Based on observation with the maintenance director on 11/02/11 at 2:10 p.m., the corridor door for room 315 which was being used as a storage room for combustibles materials such as mattresses, linens and supplies in cardboard cartons was tested three times with the maintenance director. Each time the door failed to latch into the door frame. The maintenance director said at the time of observation, the latch mechanism needed work. 3.1-19(b)			
K0048 SS=F	There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 18.7.1.1 Based on record review and interview, the facility failed to include all elements for the extinguishment of fire in the written fire plan for the protection of 38 of 38 residents in the event of an emergency. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms	K0048	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;No residents were found to have been affected. The fire safety plan has been updated to include the appropriate use of K class fire extinguishers as well as clarification regarding "major" and "minor" fire response. How other residents having the potetial to be affected by the same deficient practice will be identified	12/02/2011

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	(2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire This deficient practice could affect all occupants. Findings include: Based on review of the facility Disaster Plan which included their fire safety plan on 11/02/11 at 10:45 a.m. with the maintenance director, item # 8 of the plan addressed the use of fire extinguishers but failed to include the appropriate use of three K class fire extinguishers located in the kitchen. Item # 14 referred to a "MAJOR" fire and a "minor fire that is out of control" and steps to take. The maintenance director agreed, there could be no distinction made for response to fire. 3.1-19(b)		and what corrective action(s) will be taken;All residents were found to have the potential to be affected. No residents were found to have been affected. The fire safety plan has been updated to include the appropriate use of K class fire extinguishers as well as clarification regarding "major" and "minor" fire response. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur;Disaster and fire safety plan will be reviewed annually to help ensure any needed changes or clarifications are made.How the corrctive action(s) will be monitred to ensure the deficient practice does not recur; QA committee will receive verification anually following review of the disaster and fire safety plan. All systemic changes will be completed by 12/2/11	

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K0154 SS=C	Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 Based on record review and interview, the facility failed to provide a complete written policy containing procedures to be followed to protect 38 of 38 residents in the event the automatic sprinkler system has to be placed out of service for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.7.6.1. LSC, 9.7.6.2 requires sprinkler impairment procedures comply with NFPA 25, Standard for Inspection, Testing and Maintenance of Water Based Fire Protection Systems. NFPA 25, 11-5(d) requires the local fire department to be notified of a sprinkler impairment and 11-5(e) requires the insurance carrier, alarm company, building owner/manager and other authorities having jurisdiction also to be notified. This deficient practice could affect all occupants	K0154	What corrective acton(s) will be accomplished for those residents found to have been affected by the deficient practice;No residents were found to have been affected. The FireWatch Sprinkler Policy has been updated to include the implementation of the fire watch when the sprinkler system is out of service for four hours or more in a 24 hour period. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;All residents had the potential to be affected however no residents were found to have been affected. The Fire Watch Sprinkler Policy has been updated to include the implementation of the fire watch when the when the sprinkler system is down for fourhours or more in a 24 hour period. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; The Disaster and Fire Safety Plan will be reviewed annually to help	12/02/2011

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	in the facility including residents, staff and visitors. Findings include: Based on review of the facility's Fire Watch Sprinkler Policy with the maintenance director on 11/02/11 at 10:55 a.m., the fire watch procedure for an out of service automatic sprinkler system was not complete. The procedures failed to include the implementation of the fire watch when the system was out of service for four hours or more in a 24 hour period. The maintenance director agreed at the time of record review, the requirement was omitted from the policy. 3.1-19(b)		ensure any needed changes are made. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; QA committee will receive verification of review of the Disaster and Fire Safety Plan annually. All systemic changes will be completed by 12/2/11.	

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K0155 SS=C	Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 Based on observation and interview, the facility failed to provide a complete written policy containing procedures to be followed to protect 38 of 38 residents in the event the fire alarm system has to be placed out of service for four hours within a 24 hour period in accordance with LSC, Section 9.6.1.8. LSC 19.7.1.1 requires every health care occupancy to have in effect and available to all supervisory personnel a plan for the protection of all persons. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the facility's Fire Watch Alarm Policy with the maintenance director on 11/02/11 at 10:50 a.m., the fire watch policy and procedure for an out of service automatic fire alarm system was not complete. The	K0155	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;No residents were found to have been affected. The Fire Watch Alarm policy has been updated to include all elements of the NFPA Life Safety Code Standard when the fire alarm system is out of service for more than 4 hours in a 24 hour period. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective acton(s) will be taken;All residents had the potential to be affected however no residents were found to have been affected. The Fire Watch Alarm policy has been updated to include all elements of the NFPA Life Safety Code Standard when the fire alarm system is out of service for more than 4 hours in a 24 hour period. What measues will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; The Disaster and Fire Safety Plan will be reviewed annually to help ensure any needed changes are made. How the corrective action(s) will be	12/02/2011

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	procedures did not include the implementation of the fire watch when the system was out of service four or more hours in a 24 hour period. The maintenance director agreed at the time of the record review, this element had been omitted from the plan. 3.1-19(b)		monitored to ensure the deficent practice does not recur;QA committee will recieve verification of reivew of the Disaster and Fire Safety Plan annually. All systemic changes will be completed by 12/2/11	